A Submission to the American Psychiatric Association
by the Australian Psychological Society

on DSM-5 Draft Criteria

15 June 2012

Contacts:
Professor Simon Crowe
s.crowe@latrobe.edu.au

Professor Lyn Littlefield
l.littlefield@psychology.org.au
Acknowledgments

The APS wishes to acknowledge the contribution of the DSM-5 Reference Group:

Professor Mike Kyrios, Swinburne University of Technology
Professor Erica Frydenberg, The University of Melbourne
Professor David Kavanagh, Queensland University of Technology
Professor Greg Murray, Swinburne University of Technology
Professor Sue Spence, Griffith University
Dr Nicholas Voudouris, Australian Psychology Accreditation Council
Mr David Stokes, The Australian Psychological Society
Dr Rebecca Mathews, The Australian Psychological Society

The APS also acknowledges the work of David Kavanagh and Greg Murray in preparing the introductory section of this document and for editing and integrating the contributions from the different panels formed to provide input.

In addition the following members of the different panels contributed their time and expertise by providing input to the final document:
Professor Nick Allen, School of Psychological Sciences, The University of Melbourne
Professor Tony Attwood, School of Applied Psychology, Griffith University
Professor Mark Creamer, Department of Psychiatry, The University of Melbourne
Professor Mark Dadds, School of Psychology, University of New South Wales
Associate Professor Cheryl Dissanayake, Olga Tennison Autism Research Centre, La Trobe University
Dr Lynette Evans, School of Psychological Science, La Trobe University
Dr John Farhall, School of Psychological Science, La Trobe University
Professor David Forbes, Department of Psychiatry, The University of Melbourne
Professor Brin Grenyer, School of Psychology, University of Wollongong
Professor Nicholas Haslam, School of Psychological Sciences, The University of Melbourne
Professor Anthony Jorm, Centre for Youth Mental Health, The University of Melbourne
Dr Chris Lee, School of Psychology, Murdoch University
Dr Joseph Lee, Private Practitioner
Professor Andrew Mackinnon, Centre for Youth Mental Health, The University of Melbourne
Professor Marita McCabe, Faculty of Health, Deakin University
Professor Jeannette Milgrom, School of Psychological Sciences, The University of Melbourne
Mr Tim McCorriston, Laburnum Psychology
Associate Professor Rosemary Purcell, Centre for Youth Mental Health, The University of Melbourne
Dr Yvonne Stolk, Transcultural Psychology Consultant
Dr Neil Thomas, Faculty of Life and Social Sciences, Swinburne University
Dr Giacomo Vivanti, Olga Tennison Autism Research Centre, La Trobe University
Professor Tracey Wade, School of Psychology, Flinders University

While the APS acknowledges the contributions of all these experts, it recognises that in the process of integrating information from a range of sources, the final document may not fully reflect the views held by individual contributors.
Submission by the Australian Psychological Society

General Comments

The Australian Psychological Society (APS) acknowledges the scale and complexity of the DSM-5 revision process, and commends the systematic and explicit use of research to guide the development of DSM-5. In particular, we applaud the sceptical approach to both long-standing and emerging constructs, as exemplified conceptually in the agenda-setting white papers and empirically in the field trials. This openness to new evidence and ideas is well balanced against the need to retain continuity with previous editions, in recognition of the fact that major changes in DSM-5 would challenge the knowledge and practice that have built up around the earlier terminology. The Society is aware that many of the issues surrounding diagnoses are subject to a plurality of views, including opinions concerning the interpretation of research evidence, and recognises the difficulty in resolution of those views in DSM-5.

The APS also commends the attempts to make the DSM-5 revision process more transparent and inclusive than previous revisions, and the willingness to modify proposals in the light of external feedback (e.g., in relation to ‘attenuated psychosis syndrome’). However, we still await a full draft of the DSM, and the ability to comment is limited by the information provided on the web site. For example, the APS assumes that a multiaxial approach will be retained, and that introductory material will still contain strong caveats and cautions about use of the manual, but note that details concerning these issues and specific text are not yet available for comment. The timeline for completion has placed significant constraints on the ability to address several research questions that have emerged during the process, and to fully integrate emerging research and critical comment into the full text of the revision.

The APS applauds the attention to potential conflicts of interest in the revision process, but notes that the potential for influence by non-scientific factors remains. For example, removal of the bereavement exemption from the diagnosis of major depressive disorder is strongly supported by evidence (bereavement is one of many serious losses that may trigger depression), but this became caught up in broader discussions about ‘medicalisation’ of normal distress. Although this is a legitimate concern, we propose it should be addressed at the conceptual level where it belongs (viz., the status of causes, especially psychosocial causes, in the logic of the taxonomy), rather
than on this particular issue where the data provides strong grounds for a revision.

The Society acknowledges that recent versions of DSM have attempted to avoid alignment with a particular theoretical or empirical framework. However, they inevitably sit within a biomedical paradigm of mental health, and there is concern that (unless modified) this model has significant limitations as a framework for research and practice. Amongst these is an inadequate consideration of the social relativity of many psychological problems (the proposed criteria for substance use disorders constitute a prime example, but the issue has wider impact).

Furthermore, any classification that primarily focuses on problems or deficits at the expense of personal achievements, resources and preserved aspects of functioning or wellbeing runs the risk of overdiagnosis, discrimination and stigma, and an undermining of self-efficacy and motivation. These risks are particularly acute where the diagnosis carries implications of poor prognosis (as in personality disorders), and the APS argues that such implications should be avoided in the descriptions of disorders. Negative effects of diagnosis could be reduced (and both research and treatment better informed) by an increased focus on the classification of strengths as well as deficits, and such a focus would bring DSM more in line with current conceptions of recovery in mental disorder (including the preservation and development of hope and fulfilment, regardless of symptom status).

The Society concurs with the President of the American Psychiatric Association and the Director of the NIMH, who recently reiterated that the scientific basis for an etiologically valid classification of mental disorders remains inadequate. Consequently, the various entities presented in DSM-5 (symptoms, diagnoses, disorder groupings, classification structure, etc.) remain hypotheses, not discoveries. Indeed, the changes initiated by DSM-5 demonstrate that psychiatric classification is always a work in progress. It is therefore critical that the DSM-5 text include explicit advice about the risk of reification of diagnoses.

The APS strongly supports the recognition of dimensionality in mental disorders, as operationalised in cross-cutting dimensions and severity indices. This recognition accords with substantial research evidence that most mental disorders differ by degrees from normality and from one another, rather than representing discrete, bounded categories. The Society also accords with psychological evidence that a modest number of symptom or trait dimensions underlie most forms of psychopathology, and that
dimensional measures are generally more reliable and valid than DSM-IV’s categorical diagnoses.

Although DSM-5 is to be commended for taking dimensionality seriously, detailed definitions and assessments for these dimensions are not compelling at present. The website is unclear about the relationship between DSM-5 cross-cutting measures and Promis measures, and the presented Level 1 patient-report instruments are patently early drafts. There is no common approach to the issue of severity assessment: in some disorders (e.g., Bipolar I) there is a global rating, which in the case of depressive disorders is not specific to those disorders. In some (e.g., Dissociative Amnesia, Somatic Symptom Disorder) a specific assessment tool is described, and in others (e.g., psychoses, Post-Traumatic Stress Disorder), each symptom is given a severity rating. In other domains (e.g., substance use and addictive disorders) a count of criteria is offered, while in some (e.g., Autism Spectrum Disorder) criteria relate to the degree of support required. In many cases, draft severity criteria have not yet been presented. A consistent approach is needed, which captures both the severity of specific features and the range of criteria met. In essence, severity ratings represent measures, and these measures should be subjected to the usual psychometric requirements for the development of assessment instruments. Given the current status of the proposed cross-cutting and severity measures, further research and consultation will be needed before these critical components are finalised.

The polythetic approach to diagnosis (only a subset of criteria being required) will continue to generate issues with diagnostic heterogeneity in DSM-5. The APS notes that in some disorders, there are increased requirements that specific symptoms be present (e.g., in Criterion A of Schizophrenia) or there has been an increase in the number of required criteria (e.g., in substance use disorders vs. substance abuse). However in the latter case, this is in the context of a new set of diagnoses with more criteria than before. Substantial levels of heterogeneity within a disorder inhibit the understanding of its epidemiology, and introduce a lack of clarity to communication.

Finally, in some cases (e.g., substance use and addictive disorders and Autism Spectrum Disorder), the current revision has taken DSM further away from comparability with ICD. The Society recognises that the ICD revision is a separate process, and does not pre-empt decisions that may subsequently be made to realign ICD with DSM-5. However, there is a risk that inadequate consideration of the cross-cultural and international applicability of criteria within the current revision process will constitute a significant
limitation to the consistent application of DSM across cultural and national contexts. Since any classification of disorders should be attempting to capture problems experienced by humanity rather than problems of a specific culture, the issue has potential to affect both international communication and fundamental research and understanding.
Comments on selected disorders and categories

NEURODEVELOPMENTAL DISORDERS

Autism Spectrum Disorder
The term Autism Spectrum Disorder is seen as preferable to Pervasive Developmental Disorder, and more consistent with the terminology commonly used by clinicians and researchers.

The elimination of DSM-IV subtypes of Autism Spectrum Disorder appears justified by research showing that symptoms and risk factors in Autistic Disorder, Asperger's Disorder and Pervasive Developmental Disorder-Not Otherwise Specified are more similar than different (e.g., Macintosh & Dissanayake, 2004; and as reflected in poor reliability in subtype diagnosis across sites; Lord, et al., 2012). The decision is also substantiated by the poor reliability in subtype diagnosis across sites and in the extent of variability in the severity and relevance of the symptoms within the diagnostic subtypes. The proposed new category of Autism Spectrum Disorder reflects this combination of homogeneity in the core symptoms and heterogeneity in their severity, giving up on the idea that such heterogeneity can be captured by a discrete number of mutually exclusive categories. This both simplifies the diagnostic process, and potentially increases diagnostic reliability.

The change in criteria from three domains of impairment (social, communication and fixated interests/repetitive behaviours) into two (social/communication and fixated interests/repetitive behaviours) is parsimonious, but some clinicians see utility in the more differentiated earlier criteria. While the inclusion of *hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment* is consistent with clinical experience, research and autobiographies, it is unclear why this characteristic is considered an expression of *Restricted, repetitive patterns of behaviour*.

The APS notes the possibility that some individuals currently diagnosed with a Pervasive Developmental Disorder will be classified under the new category of Social Communication Disorder, which appears very similar to an Autism Spectrum Disorder, but for which there are no treatment guidelines. Moreover, it is possible that the next edition of the ICD will not conform to the new DSM-5 criteria, thus jeopardising the international consensus about diagnostic criteria which has supported the progression of research on autism over previous decades.
Overall, the new criteria reflect current understanding of Autism Spectrum Disorder better than the current DSM-IV categories. As expected with any major change in classification systems, there are also significant risks, which will have to be carefully monitored and addressed by both policy makers and the scientific community to ensure that best clinical practice and research are facilitated.

**PSYCHOTIC DISORDERS**

Now that the contentious Attenuated Psychosis Syndrome has been omitted from the main scheme (and moved to Section III, disorders warranting further research), revisions to the psychotic disorders are largely refinements of existing classifications, plus incorporation of dimensional aspects of psychosis.

In line with contemporary thinking that psychotic presentations are not distinct disease entities but vary fluidly on a number of continua, psychologists have been strong advocates of symptom-focused (Bentall, Jackson, & Pilgrim, 1988) and dimensional (Van Os et al., 1999) approaches as alternatives to the taxometric system used in DSM. Most psychological literature on psychosis addresses psychological processes associated with either individual psychotic symptoms or psychosis broadly, rather than processes specific to particular psychotic disorders. Correspondingly, in clinical work with psychosis, symptom-level formulation is more useful to psychologists in informing treatment than diagnosis. Nonetheless, in grouping together similar populations for research, the schizophrenia taxonomy remains used by many psychologists as a ‘model’ non-affective psychotic syndrome in which to study psychotic processes.

Criticisms remain about retaining the Kraepelinian division between schizophrenia-related and affective psychosis (Craddock & Owen, 2010). However, incorporating psychosis dimension scales appears a workable compromise in aligning the existing classification-based system with contemporary concepts of psychosis (Allardyce, Suppes, & Van Os, 2007). The dimensions successfully incorporate both empirically-derived factors and key symptoms. Including cognition, depression and mania dimensions is particularly welcome in drawing attention to important but often under-recognised features of psychotic presentations. In providing pragmatic groupings for research, the Society also welcomes the improved homogeneity of schizophrenia and tighter definition of schizoaffective disorder as syndromes.
However, whilst presenting schizophrenia-related disorders as a spectrum (and including schizotypal personality disorder) is helpful, it seems misleading to present them in an increasing ‘gradient of psychopathology’. This ordering is neither empirically derived nor reflective of how the taxonomy of psychotic disorders has evolved, and is unlikely to be widely accepted by experts in the field. The psychosis syndromes vary from each other in multiple ways rather than just severity, and this appears important to convey.

**BIPOLAR AND RELATED DISORDERS**

DSM-5 revisions to the bipolar disorders occur in the scientific context of unresolved fundamental questions about their optimal description. Spectrum relationships exist **within** the bipolar disorders, and **between** the bipolar disorders and each of psychotic disorders, unipolar depression and normality. State-like and trait-like features are well documented and plausible bipolar disorder endophenotypes make strong connections across the DSM classification (e.g., sleep, activity, positive affect regulation). The relationship between manic and (the probably multiple) depression phenotypes is unclear but the two propensities may be best understood as separable and correlated. Significant comorbidities with anxiety, substance use and personality disorders further suggest that the bipolar disorders may be misrepresented as a simple suite of categorical mood diagnoses. Growing recognition of the strengths that covary with the various phenotypes (e.g., creativity, drive, academic achievement) further problematise disorder assumptions.

The APS notes the generally low reliability of clinical diagnoses of bipolar disorder, and the consequent risk of over-diagnosis and hence, in practice, over-medication. Hence, there is concern that the proposed new disorder, Dysregulated Mood Disorder with Dysphoria (DMDD), has not been sufficiently researched (see also above). The operational definition has changed significantly as the concept has evolved from severe mood dysregulation through temper dysregulation disorder with dysphoria, to DMDD. This diagnosis would therefore be better placed in Section III.

Many of the other changes proposed for DSM-5 are well founded. The addition of increased energy/activity as a core symptom of Manic and Hypomanic episodes is consistent with evidence on the phenomenology of elevated mood states (and aligns with an important endophenotype). The Society also agrees that exploring for a history of hypomania using the core symptom of activity may help with the problem of under-reporting by currently depressed patients. It is noted, however, that the current stem
criterion requires activity and mood changes, and it is not clear that consequent improvements in specificity outweigh the loss of sensitivity. The Society would like to see a stronger rationale for not adopting an either/or stem criterion.

The long-standing metaphor of bipolar disorder as a cycling between opposite poles of depression and mania is an oversimplification, as exemplified by the common co-occurrence of depressive and manic symptoms. The APS therefore commends the broader recognition of mixed states, by way of replacing Mixed Episode with a Mixed Features specifier for all three episode types. The current iteration of the Mixed Features specifier is very complex, however, and may be difficult for clinicians to apply reliably.

In DSM-IV, bipolar and depressive disorders were combined in a Mood Disorders chapter. The current information on the web site suggests that Bipolar Disorders will sit in a separate chapter to Depressive Disorders. This parsing is consistent with the marked differences between these two types of disorder, particularly in terms of poorer prognosis in bipolar disorders. It appears that DSM-5 will nonetheless continue to recognise only one type of major depressive episode (MDE) across both types of disorder. Particularly noteworthy is the fact that the Mixed Features specifier is proposed to apply to a MDE making up a Major Depressive Disorder diagnosis, when part of the rationale for this specifier was its sensitivity to a bipolar diathesis. Given the important clinical implications of a bipolar vs. unipolar diathesis in a presenting MDE, the Society recommends that the text associated with MDE includes some evidence-based comment about this issue.

The duration of episodes has received substantial attention in recent literature, with current data suggesting that hypomania is often of 2 or 3 days duration, and that these briefer periods are still associated with impairment. To balance accurate phenomenology with concerns about over-diagnosis, the threshold for hypomania could be set at two or more incidents of two or more days of increased energy or elevated/irritable mood.

Finally, it concurs with the retention of cyclothymic disorder, which epidemiological studies find is prevalent and associated with considerable impairment. Cyclothymic disorder creates a target for early intervention and possibly more titrated treatments and options in addition to somatic treatments.
DEPRESSIVE DISORDERS

The evidence base cited for some of the proposed changes in depressive disorders appears inadequate. Given that depressive disorders do not reflect natural categories (i.e., disorder is continuous with non-disorder), the APS submits that the fundamental reason for having a classificatory distinction is that it predicts differential epidemiology, prognoses and responses to intervention. The draft gives no indication that evidence on intervention outcomes was considered.

Some of the listed disorders combine etiology with symptomatology. While this is appropriate for single-cause disorders, depressive disorders often have multiple complex causes. As a result, it is often impossible to attribute a disorder to a specific cause, such as substance use, bereavement or another medical condition. The APS believes it would be more sensible to record likely causes separately from the diagnosis.

As with other disorders, it supports the idea of providing an indication of severity. However, the proposed severity ratings for depression are for mental disorders in general. There needs to be quantitative measures of severity specific to depressive disorders. It supports the use of a standard established measure such as the PHQ-9 for this purpose.

It is noted that the new postpartum specifier is 6 months. We suggest that this specification remains too restrictive. In everyday clinical and research use, the definition of postnatal depression is often depression occurring in the first 12 months following childbirth. Some of the best meta-data on prevalence even suggest a peak in prevalence at 8 months (Gavin et al, 2005).

Disruptive Mood Dysregulation Disorder
Given this is a new diagnosis, a more thorough rationale is required. Criterion E makes DMDD a more severe diagnosis than ODD, but the rationale for its positioning within the Depressive Disorders rather than Conduct Disorders is insufficient, given the extent that it shares externalising features with those disorders. What are the exclusion criteria? Determining onset of criteria A to E before the age of 10 years may prove difficult in practice, as reliable evidence on the timing of onset may not be present. The rationale for selection of the age of 10 years is also unclear, and the Society is concerned about the potential misuse of this diagnosis if it is applied retrospectively.
**Premenstrual Dysphoric Disorder**
The APS supports the specification of this disorder as a separate diagnostic category. Exclusion E (exclusion of other medical causes) may be time-consuming to establish in practice.

**Depressive Disorder NEC**
The APS commends the Mood Disorders working group on their careful review of Not Elsewhere Classified options for both bipolar and depressive disorders, and the opportunity to describe cases more definitively in Depressive Disorder NEC is potentially useful.

However, the category of Minor Depressive Disorder had utility for both clinicians and researchers (e.g. in describing a common perinatal condition requiring treatment), and its elimination in favour of a less stringent and broader category represents a reduction in precision and recognition, since many will now be classified as having a Subthreshold Depressive Episode with Insufficient Symptoms.

The bar for ‘diagnosis’ is set much lower and more vaguely in these commonly used groupings and that the term ‘disorders’ is therefore inappropriate and should be replaced with the term ‘conditions’.

**OBSESSIVE-COMPULSIVE & RELATED DISORDERS (OCRD)**

The proposed Obsessive-Compulsive and Related Disorders (OCRD) category brings together a range of disorders with complex underlying dimensionality (e.g., anxiety, impulsive-compulsive, somatoform).

There is no clear justification of the specific disorders selected for inclusion in the OCRD category, and of the exclusion of other potential candidates. For example, Body Dysmorphic Disorder is now included in OCRDs, but not Hypochondriasis—a disorder with considerable similarity to OCD. On the other hand, Skin Picking and Trichotillomania are included in the OCRD category but could just as easily be seen as behavioural addictions or impulse control disorders. Moreover, there is insufficient justification of the separation of the OCRD category from other anxiety disorders.

The premise that OCD should be distinguished from those disorders, even though its main presenting characteristic is anxiety, is not supported universally within and across various mental health professions (Stein et al., 2010).

The APS commends the inclusion of Hoarding Disorder as a separate disorder in DSM-5, emphasising its separation from OCD and Obsessive-
Compulsive Personality Disorder and clearing up confusion about hoarding in previous editions of DSM. This change is supported by the research evidence and will have important positive resource and practice implications for mental health and social policy.

**POSTTRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER**

The APS endorses the decision to remove Acute Stress Disorder and Posttraumatic Stress Disorder from the anxiety disorders category and place it in a new category "Trauma- and Stressor-related Disorders" (which also includes the Adjustment Disorder diagnoses), on the grounds that Acute Stress Disorder and PTSD are two of the few diagnoses with the etiology built into the criteria. It could also have been argued that both disorders sit as much in the mood or dissociative disorders categories as in the anxiety disorders. Therefore placement in this new category is to be supported.

**Post-Traumatic Stress Disorder**

Under the event Criterion A, the Society supports the inclusion of repeated exposure to stories about traumatic events, allowing the range of risks experienced by police and other emergency services to be more fully recognised. The proposed definition also clarifies where exposure through the electronic medium sits in relation to the disorder, in terms of limiting the extensiveness of meeting criteria through news program exposure, but also providing explicit recognition to those where exposure through electronic media is work-related. The deletion of Criterion A2 (the response criterion) is also supported empirically, in that it did not add sufficiently to diagnosis and created unnecessary complications for those exposed in contexts of military and emergency service work, where immediate responsivity is driven by functional role imperatives which may temporarily mask emotional responses.

Increased specifications around nightmare Criterion B2 are useful to reflect content or affect consistent with the event.

The splitting of the avoidance and numbing symptoms into two distinct clusters (DSM-5 Criteria C & D) is the most significant change. It has been mooted for some time and consistent with the available research. The APS also believes it will improve diagnostic specificity of the disorder.

What was passive avoidance and numbing has now been expanded significantly under the cluster of “negative alterations to cognition and mood” (Criterion D). There seems to be little empirical justification for some of these features. In particular, the new category does not capture
emotional numbing in the same way and is heavily loaded toward depression at the expense of predominantly anxious or fearful presentations.

Concerning marked alterations in arousal and reactivity (Criterion E), the additional symptom, “reckless or self destructive behaviour” has been included without strong empirical support, and the parameters for this criterion are unclear.

**Acute Stress Disorder**

Many of the issues raised above also apply to Acute Stress Disorder. For example, reduced emphasis on dissociation as a requirement for the disorder is consistent with the empirical literature on the important but not necessary role of dissociation in the development of Post-Traumatic Stress Disorder. The rationale for and the benefits of retaining this diagnosis have yet to be demonstrated. Its linkage with subsequent Post-Traumatic Stress Disorder is potentially undermined by the fact that modifications to DSM-5 Acute Stress Disorder do not retain the same phenomenological structure as DSM-5 Post-Traumatic Stress Disorder.

**EATING DISORDERS**

Criteria not currently considered in the DSM may be important to consider in future diagnostic criteria, particularly those identified by latent class and profile analyses as indicating a more clinically severe disorder (e.g., presence of comorbidity particularly depression), or personality traits that seem to meaningfully differentiate between low weight restricting disorders and binge eating disorders (associated with low, normal or overweight).

**Anorexia Nervosa**

Removal of a specific BMI in Criterion A is supported, although DSM needs to provide an accepted interpretation of ‘significantly low weight’ (e.g. for children and adolescents, using 2000 CDC charts). The removal of the term “refusal” is also an advance, since this removes the attribution of “wilfulness”. Changes in Criteria B and C also appear to be improvements, and in particular, the APS submits that the removal of the term “denial” is an excellent development which together with the elimination of ‘refusal’ from Criterion A, will promote a more collaborative relationship in treatment. Removal of amenorrhea from Criterion D is well supported by the empirical literature. The distinction of Restricting and Binge Eating/Purging Anorexia Nervosa subtypes is important and its retention is supported.
**Bulimia Nervosa and Feeding or Eating Disorder Not Otherwise Specified**

The changes to these diagnoses are well aligned with the empirical data. The combination of the elimination of amenorrhea from Anorexia Nervosa, the reduction in the number of episodes required to obtain a diagnosis of Bulimia Nervosa, and the development of a separate Binge Eating Disorder diagnosis are likely to produce an improved specification of several problems that were previously in the ‘Not Otherwise Specified’ category.

**Binge Eating Disorder**

There is insufficient rationale for the lack of consistency between the criteria used for binge eating in the Bulimia Nervosa diagnosis and the more extensive criteria in this diagnosis. The APS suggests that further consideration of the definition of binges in both disorders should be undertaken.

**SEXUAL DYSFUNCTIONS**

The APS supports the clarification of specifiers from DSM-IV Sexual Dysfunction. Recognition of the complex interaction between excitement, desire and arousal and the concomitant attempt to acknowledge the individual’s unique experiences of all phases are seen as important, since it identifies the dynamic interaction between these phases of sexual functioning and highlights the need for clinicians to pay attention to the individual’s experience in assessing the specific sexual dysfunction (e.g., in early ejaculation). The Society also support the continued inclusion of explicit acknowledgement that individuals with sexual disorders may present with multiple diagnoses and the recognition that sexual dysfunction has a combination of possible physical and psychological features that interact. This sophisticated model of sexual dysfunction assists clinicians to be aware of the need to assess physical complaints when considering psychological complaints.

Definitions of all disorders have been expanded and more clearly specified. Relabeling of the disorders such as Early Ejaculation, Female Sexual Arousal Disorder and Genito-Pelvic/Pain Penetration Disorder are clearer than in DSM-IV. The more general description in the Genito-Pelvic Pain Penetration category has extended the diagnosis to make it clearer that both genders experience this disorder. The only shortcoming with this particular disorder in DSM-5 is its cumbersome label.

A major change is the combination of female sexual interest and sexual arousal for women (but not for men). This combination is not seen to be a
useful step either for clinical practice or research studies. Although there is some overlap in sexual interest and arousal, there are also distinct differences in these two aspects of sexual responses. By combining these two aspects of the sexual response cycle, there is a blurring of these differences, and a wide range of problems are now placed under a single category. Furthermore, individuals may experience only one aspect. The rationale for the combination for females but the continued separation for males is also inadequate. Even an examination of the six specifiers of the disorder demonstrates the broad range of expressions of the new category. In the interests of science and clinical practice, the APS strongly encourages the committee to reconsider the step of combining these two disorders.

**DISRUPTIVE, IMPULSE CONTROL AND CONDUCT DISORDERS**

The separation of Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) is a difficult issue. ODD and CD have some unique correlates/trajectories, but they have many in common. It is difficult to see what is gained by proposing that a child who meets criteria for CD also meets criteria for ODD, although the reverse may be more useful, in that the majority of children with ODD will not meet criteria for CD. In the long run it may be more useful to have a diagnosis that combines ODD/CD into the same disorder, while operationalising developmentally equivalent symptoms (e.g., non-compliance in early childhood / serious rule-breaking in adolescence), and including a specifier/subtyping option concerning the presence of physical aggression (which developmental research indicates is a major marker in early childhood).

The APS acknowledges the advantages of organising ODD symptoms into emotional and behavioural domains, but suggests there is a risk that the distinction could create confusion: possibly suggesting a kind of quasi-subtyping analogous to the existing ADHD diagnoses (e.g., potentially viewing the ‘vindictive’ symptom as an equivalent to the callous and unemotional (CU) ‘specifier’). The Society submits that the distinction is not worth the risk of this perception unless more fundamental changes to the criteria are made.

The APS supports the development of a severity index based on the cross-situation pervasiveness of the symptoms, since this change may encourage multi-informant assessment.

The APS does not see how it would be feasible to specify objective and standard definitions of raw frequencies for the ODD symptom threshold that could be applied across a range of developmental periods. The ability to
determine whether symptoms are developmentally excessive for an individual case should be a core skill for an assessing clinician.

The proposal to include a Callous and Unemotional (CU) Trait specifier is important and raises several questions. Why is the specifier applicable to CD but not ODD? How well supported is this proposal by the existing research? The evidence for CU traits modifying the CD diagnosis comes from a range of research domains including behavioural genetics and parenting. High and low CU traits in CD children are differentially implicated in etiology, neuropsychiatric and neurological functioning, prognosis, and treatment outcomes. Some of this research applies to CU traits in community samples and importantly, CU traits as a modifier of ODD rather than CD.

The inclusion of a CU trait specifier may be clinically useful in encouraging clinicians to group CD and ODD children more carefully. A small number of studies have indicated that CU moderates treatment outcome but little is known about how best to work with high CU traits in CD children and adolescents.

The evidence indicates CU traits are probably normally distributed in human populations and many of its correlates have been shown in people free of conduct problems. A high level of CU traits does appear to “modify” the nature of CD. The specification of a “personality” variable as a modifier of an Axis I disorder is an interesting idea, but brings many theoretical and practical issues and implications, amongst which is the potential for trait-related modifiers elsewhere in DSM-5. The construct “doesn’t show emotions” or “shallow emotions” which is proposed as a component of CU, originated on the narcissism subscale of the APSD and is not reliable as a marker of CU traits. Some of the constructs for measuring CU are presented in the first voice, but the measurement of CU traits by self-report is still undeveloped psychometrically.

**Disruptive Behavior Disorder Not Elsewhere Classified**

The APS submits that it would be a significant improvement to eliminate this diagnosis, as one that reduces the specificity of diagnoses in this category.

**Intermittent Explosive Disorder**

This disorder includes a wide set of indicators, and verbal aggression twice a week is broad and represents too low a criterion to warrant inclusion. Insufficient evidence has been presented on its nosology, measurement, reliability, validity, sensitivity and specificity, independent correlates, and distinction from ODD.
SUBSTANCE USE AND ADDICTIVE DISORDERS

The distinction between abuse and dependence has not withstood empirical scrutiny, and unitary diagnoses with levels of severity appear well substantiated. As others have noted, dropping legal problems reduces problems with differing legal contexts, and while the social relativity of Criteria 4-6 limits the comparability of diagnoses across national and subcultural contexts, the Society argues that social impacts of addictive disorders are important to capture (Kavanagh, 2011). However, it may be useful to create an index reflecting the degree of reliance on social criteria.

A specific issue is raised by a potential overlap between failure to fulfill major role obligations and giving up important activities, which may result in some actions being counted against both criteria: The APS recommends further study to examine the impact of rolling those into a single criterion. The addition of a craving criterion is applauded, given the frequency and functional impact of this feature.

The fact that a mild disorder can be diagnosed with only 2 of 10-11 criteria being fulfilled (depending on the substance) means that a mild substance use disorder potentially has very different forms in different individuals: In the absence of further specification, this significantly limits the informational value of the diagnosis. The requirement of 6 criteria for a severe disorder reduces heterogeneity in that group, although there remains potential for differing subgroups.

A person can obtain a diagnosis of a substance use disorder in sustained remission when they do not currently fulfill any criteria. While the Society recognises the high risk of relapse in addictive disorders, this diagnosis is potentially harmful. It is suggested that the benefits are especially likely to be outweighed by harm in cases of mild disorder in sustained remission or in cases of substance-related problems in adolescence, which do not necessarily reflect a chronic condition (Brown et al., 2008), and also in cases where recovery has been sustained over a very long period—which can even occur in untreated dependence (Moos, & Moos, 2007). The Society submits that the risk of relapse (and the need for any continued monitoring or treatment) could be captured by a lifetime diagnosis of a severe substance use or addictive disorder, and that current diagnoses should focus on current symptoms. A significant improvement in specificity could then be obtained, for example, with a combination of a severe lifetime disorder, but a mild current one. If it was felt that chronicity or recurrence was not sufficiently reflected in a lifetime diagnosis of severe disorder, a specifier to that effect could be used for the lifetime diagnosis.
There is a lack of parsimony in the separate categorisation of disorders by substance or substance type. Diagnoses of Substance Use Disorder, Intoxication or Withdrawal could be made, with the specific substance or substances as specifiers. Not only would this reduce the complexity of diagnoses within this category, it would allow greater flexibility in responses to new substances that may be developed and become used problematically. Overall, there are few differences in specification of similar disorders for different substances: Where these do occur, the distinction could be made by advice concerning the application of a criterion. Similarly, where the APS either awaits further research (e.g., Caffeine Use Disorder) or the data do not support the diagnosis (e.g., Inhalant Withdrawal), this could be covered by advice that the substance specifier was not available in that category.

**Gambling Disorder**

The APS supports the movement of Gambling Disorder into this section, because of its close parallels with other addictive disorders. However, its placement in this section throws into focus the lack of comparability between its criteria and those of substance use disorders: notably, the inclusion of preoccupation (should this be included in the craving criterion in substance use disorders?), gambling when distressed, lies to conceal gambling, and reliance on others to compensate for the problems caused by the behavior. These should receive further scrutiny as putative criteria for other addictive disorders.

In relation to specific criteria for this disorder, Criterion A1 (*needs to gamble with increasing amounts of money in order to achieve the desired excitement*), many individuals are not motivated by ‘excitement’: for example, many are motivated by escape from aversive emotions, thoughts or situations (as reflected in Criterion A5). The motivation for the increased amounts of money should perhaps be omitted. The APS supports the change in Criterion A5 (*gambles often when feeling distressed*), from ‘dysphoric mood’ to the more inclusive ‘distressed’, but note that ‘gambles as a way of escaping problems’ has been omitted. Gambling to escape problems may not necessarily be associated with current distress. It is therefore suggested that the concept of gambling to escape problems be retained. The simplification of Criterion A7 (*lies to conceal the extent of involvement with gambling*) is seen as appropriate, and it supports the elimination of the previous Criterion A8 (*has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling*) as supported by both empirical data and practical problems in eliciting reliable information on this criterion.
Substance-Induced Mental Disorders

The APS supports the retention of substantially unchanged criteria for these disorders.

Potential Disorders Recommended for Further Study in Section III of the DSM-5

*Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure*

This disorder clearly warrants attention as a potential diagnosis, although it is not clear why disorders from prenatal exposure to other substances would not also be considered.

*Internet Use Disorder*

While Internet Use Disorder appears to be gaining empirical support, its limitation to gaming may not be warranted by the available data.

A broader issue is that many other potential behavioral addictions may also be considered for inclusion over time, as technology or social behaviors change. Although the Society has concerns about potential increases in the ambit of diagnoses, a diagnosis of Other Addictive Behavior (with criteria similar to substance use disorder) may capture a range of behavioral addictions more effectively than a diagnosis that is limited to a single technological context. New specifiers could be added as evidence about specific problematic behaviors emerge. This more general diagnostic category could have greater longevity and wider application than the one that is proposed.

PERSONALITY DISORDERS

The APS commends the recognition of the core disturbance of personality disorders as impairments with self and interpersonal relations. It also supports the inclusion of a dimensional approach to personality disorder diagnosis, which better encompasses the nature of personality and its disorders, and allows assessment of level of functioning. In addition, Personality Disorder, Trait Specified allows for an idiographic understanding of the person’s personality pathology, which will assist treatment planning, although the method for doing so is questionable (e.g., trait-related rather than on the basis of impairments in functioning and adaptation).

The Society acknowledges the utility of being able to make diagnoses for people aged under 18 years (with the exception of Antisocial Personality Disorder, which is appropriate given it is indicated by Conduct Disorder for minors). This will enhance early intervention and provision of treatment for young people and their carers. However, the diagnoses of personality
disorders is particularly subject to prejudice and stigma, relating to beliefs that these disorders are likely to be lifelong and (despite substantial evidence to the contrary) that they are not amenable to treatment. The APS suggests that at least part of the problem is the language used in this category of disorders: Personality and related traits are seen as relatively enduring, cross-situational features, and in fact, these features are explicitly included in Criterion C. It suggests that the extension of these disorders to children potentially further extends the related stigma to a sub-population that is both highly vulnerable to prejudice and still in the early stages of development. So, while the Society supports early intervention in this area, it suggests that an alternative conceptualisation of these problems is needed, to reduce the risk of negative sequelae.

While a dimensional trait-related approach has theoretical appeal, its clinical utility is not well established as yet. Traits only have meaning when they are expressed in behaviours, impairment in functioning (self and interpersonal) and adaptation (Pilkonis et al., 2011). Thus, the expression of the trait is identified as pathological rather than the trait itself, which may at times be expressed in a more adaptive fashion. A separate axis would allow for patients with any psychopathology to be assessed for problematic personality traits, which may be contributing to or maintaining their condition (First, 2010).

The omission of Dependent Personality Disorder is problematic. A collection of submissive, anxious, and separation insecurity traits is unlikely to clearly differentiate dependent from Borderline and Avoidant Disorders. Dependent Personality Disorder has high clinical utility and is associated with elevated risk of physical illness, partner and child abuse, suicide risk, and high levels of functional impairment (Bornstein, 2012). Deletions of disorders, including those in the appendix of DSM-IV, may also reduce research attention.

The proposed dimensional system has not been subject to sufficient or convincing scientific research (Clarkin & Huprich, 2011; Zimmerman, 2011). How reliably can the personality traits (B criteria) be assessed based upon clinical interviews? A self-report assessment tool consisting of 220 items is under evaluation for the B criteria, however this is a large instrument that may be difficult for patients to complete in a timely fashion, particularly if they are unwell, elderly, or have a disability. How will the rating of this dimensional system be communicated? Would each person have a severity rating on each dimension so that the diagnosis of personality disorder may or may not include a particular type and percentage score on the five dimensions? Or will a clinician only report a binary presence or absence if they score extremely on a dimension? A binary outcome on the five
dimensions simply translates into a new classification system with 32 categories ($2^5$).

**PARAPHILIC DISORDERS**

One major distinction between DSM-IV-TR and DSM-5 is the separation of sexual dysfunction from gender identity disorders and Paraphilic disorders. This is a very positive move in the new DSM-5. Gender identity disorders and Paraphilic disorders do not fit well with the sexual dysfunction model related to desire and arousal disorder in sexual relationships.

The APS commends the recognition that not all paraphilias are disorders, and the attempt to draw a distinction between Paraphilic Disorder and a paraphilia. However, this distinction may be difficult to draw in a clinical setting. It is agreed that the basic structure of the Paraphilic Disorders does not warrant change.

The Society supports the distinction of subtypes in Pedophilia Disorder: classic for prepubescent children, hebephilic for early pubescent children and pedohebephilic for both. It is also appropriate to create two new categories – Hypersexual Disorder and Paraphilic Coercive Disorder. The APS has no problem about the Paraphilic Coercive Disorder, but is concerned about Sex with Consenting Adults being included as a subcategory for Hypersexual Disorder. The issue in the latter case is a difficulty in discriminating between normality and abnormality, even though there is a criterion that the disorder has to impair social, occupational or other important areas of functioning.

**DSM-5 CULTURAL FORMULATION INTERVIEW**

The Cultural Formulation Interview appears to elicit relevant values, beliefs and attitudes, while avoiding risks of stereotyping. As recommended in the DSM-IV’s Outline for a Cultural Formulation (OCF), the proposed interview will encourage consideration of cultural issues throughout the engagement and assessment process.

The APS agrees that the Cultural Formulation Interview represents a sound introduction to clinical assessment, regardless of the person’s cultural background, and suggest that it should be presented in that context. It is not clear where the interview sits in the DSM-5 manual: the location of the Outline of the Cultural Formulation in the last substantive Appendix of DSM-IV did not give the issue the degree of prominence it deserved, and was likely to have detracted from its potential impact on culturally sensitive
practice. It is recommended that the interview (and the principles underpinning it) be introduced early in the DSM-5 manual.

The Society suggests that ‘migration and settlement experiences’ be also considered in relation to factors that might be causing problems (Question 7). The wording of Question 12 (on aspects of the clinician that may make it difficult for them to understand or help with the person’s problem), may make it difficult for many patients to answer this question honestly, particularly in an initial interview. Alternative wording or substitution of instructions on the sensitive handling of this issue may be needed.

It is not clear how cultural issues are addressed within the text of diagnostic criteria, other than some references within specific diagnoses to the need to consider cultural or religious factors. Further information on how this should occur, with some specific examples, may assist.

**Conclusions**

Overall, the Australian Psychological Society sees the DSM-5 revision as implementing several improvements in the conceptualisation and definition of psychiatric disorders, but suggests that several features of the draft still require further consideration before the revision is finalised and published.
REFERENCES


First, M. B. (2010). Commentary on Krueger and Eaton’s “Personality traits and the classification of mental disorders”: real world considerations in implementing an empirically based dimensional model of personality in DSM-5. Personality Disorders: Theory, Research and Treatment, 1, 123–126. doi: 10.1037/a0019975


